York Thoracic Surgery

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THORACIC REFERRAL FORM

Diagnostic Assessment Program

SOUTHLAKE REGIONAL HEALTH CENTRE

Referral Date (YYYY/MM/DD) _____/_____/_____

PATIENT INFORMATION

Surname _____ First Name _____ DOB_____ Gender_____

OHIP/HIN # _____Preferred Phone # _____

Street Address _____ City _____ Postal Code _____

Patient Location ☐Home ☐Hospital _____

REASON FOR REFERRAL

- ☐ Diagnostic Imaging Suspicious of Lung Cancer
- ☐ Peripheral nodule or mass in smoker
- ☐ Non-peripheral mass or nodule in smoker
- ☐ Nodule or mass in non-smoker
- ☐ Multiple pulmonary nodules
- ☐ Pleural effusion
- ☐ Mediastinal or hilar adenopathy
- ☐ Slowly or non-resolving pneumonia
- ☐ Other: _____
- ☐ Clinical Symptoms Suspicious of Lung
- ☐ Massive hemoptysis
- ☐ Non-Massive hemoptysis
- ☐ Superior Vena Cava Syndrome (SVC)
- ☐ Stridor

***PLEASE ATTACH CREATININE RESULTS NO OLDER THAN 90 DAYS AND UPDATED MEDICATION LIST.**

URGENCY: ☐Emergent (<72 hrs – please call YTSA) ☐Urgent (<2weeks)

Please include all information pertinent to referral (consults, imaging reports, Bone Scan, PFT, Echocardiogram, recent blood work etc.) Date of suspicious CXR/CT scan _____/_____/_____ in clinic/hospital _____

Other tests ordered/booked _____

Relevant Medical History _____

_____

REFERRING PHYSICIAN _____Billing # _____ Phone _____ Fax _____

FAMILY PHYSICIAN _____Billing # _____ Phone _____ Fax _____

Preferred Location of Consultation

Patient to be seen at: ☐ Newmarket ☐ Barrie ☐ OSMH (Orillia) ☐HHCC (Orangeville) ☐SMH (Alliston) ☐ SRCC